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Anatomy (large)

PLATES

ILLUSTRATING A

TREATISE

ON THE

MALFORMATIONS, INJURIES, AND DISEASES

OF THE

RECTUM AND ANUS,

BY

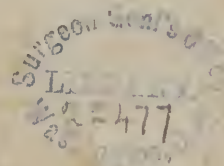
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FORMERLY PROFESSOR OF ANATOMY AND PHYSIOLOGY, &c.

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FRENCH & ADLARD, 46 BROADWAY.

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Film 8365, 3+cm 9.

PLATE I.

FIG. I. Fissure of the Anus. (See page 108.)

FIG. II. An Internal Hemorrhoidal Tumour, as large as a pullet's egg. (See page 151.)
This tumour was of seven years' standing, and for months bled profusely :
I removed it with the ligature.

Fig. 1.

Plate 1.

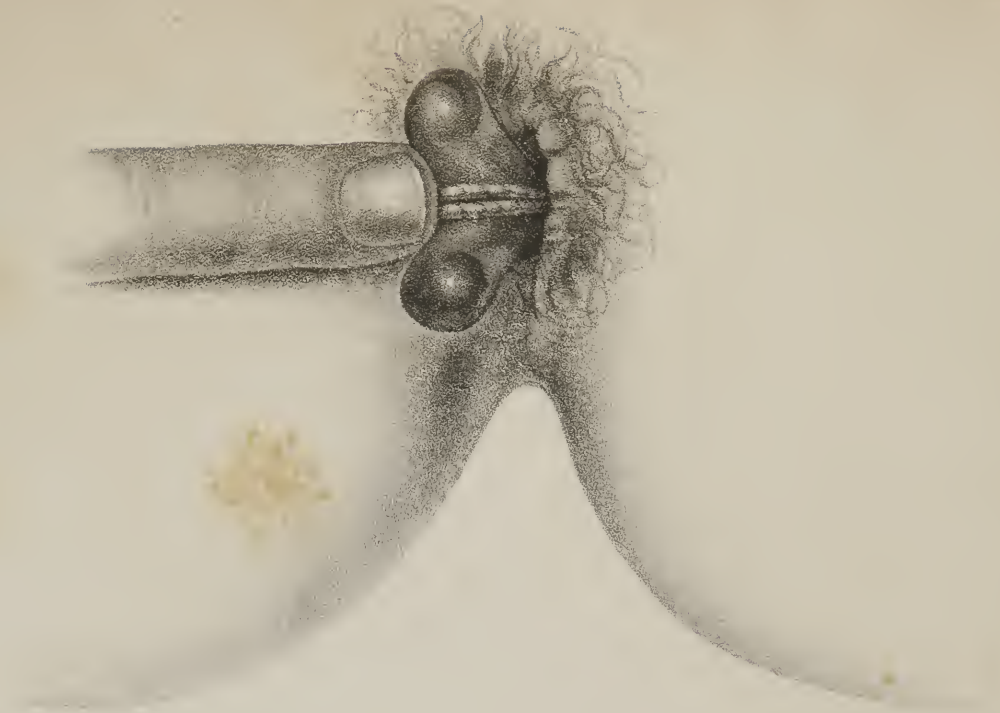


Fig. 2.



Fig 1.



Fig. 2.



Fig 3.

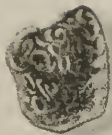


Fig 4.



Fig 5.



Fig 6.



Fig 7.

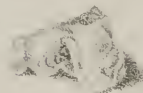


PLATE II.

FIG. I. Internal Hemorrhoidal Tumours, prolapsed. (See page 152.) I excised the tumours here depicted from a strong, young woman: the hemorrhage was alarming during the operation. (See page 183.)

FIG. II. This drawing was taken from Mr. H., on whom I operated two years ago. The more central and darker coloured protuberances are internal hemorrhoidal tumours prolapsed, while the more external and whitish nodules are portions of skin elongated, thickened, and somewhat indurated, partly from the repeated protrusion of the internal hemorrhoidal tumours, and partly from the previous extravasation of blood. (See page 163.) The skin, whether hypertrophied or not, becomes engorged when the internal hemorrhoidal tumours protrude, in consequence of the sudden interruption of the circulation, and if the prolapsus be allowed to continue, inflammation will ensue. When the internal hemorrhoidal tumours are removed, the elongated, thickened, and indurated skin generally returns to its original state in a few months; therefore, there is no necessity for removing it,—indeed such a proceeding would inevitably be followed by contraction of the anus. Both Hey and Kirby committed this error, and if I may be allowed to form an opinion from the examination of several persons operated on by B. Dupuytren, he also made the same mistake.

FIGS. III. IV. and V. Sections of internal hemorrhoidal tumours, which I removed from three different persons. They seem to consist of arteries and veins, supported by cellular tissue. (See page 152.)

FIGS. VI. and VII. Internal hemorrhoidal tumours, which have undergone a semi-cartilaginous conversion. (See page 159.)

Fig. 1.

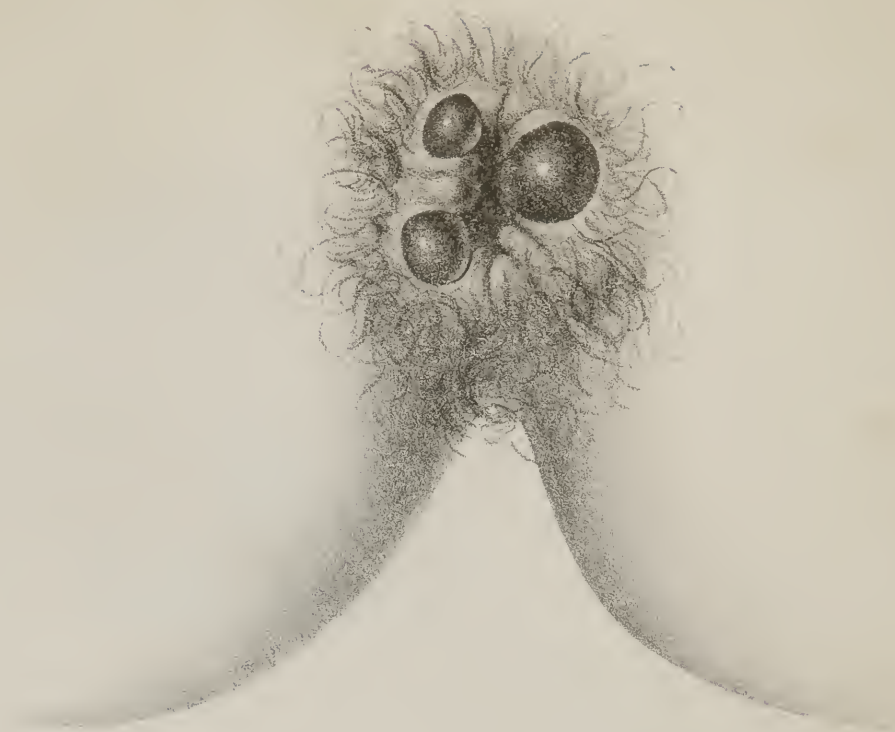


Fig. 2.

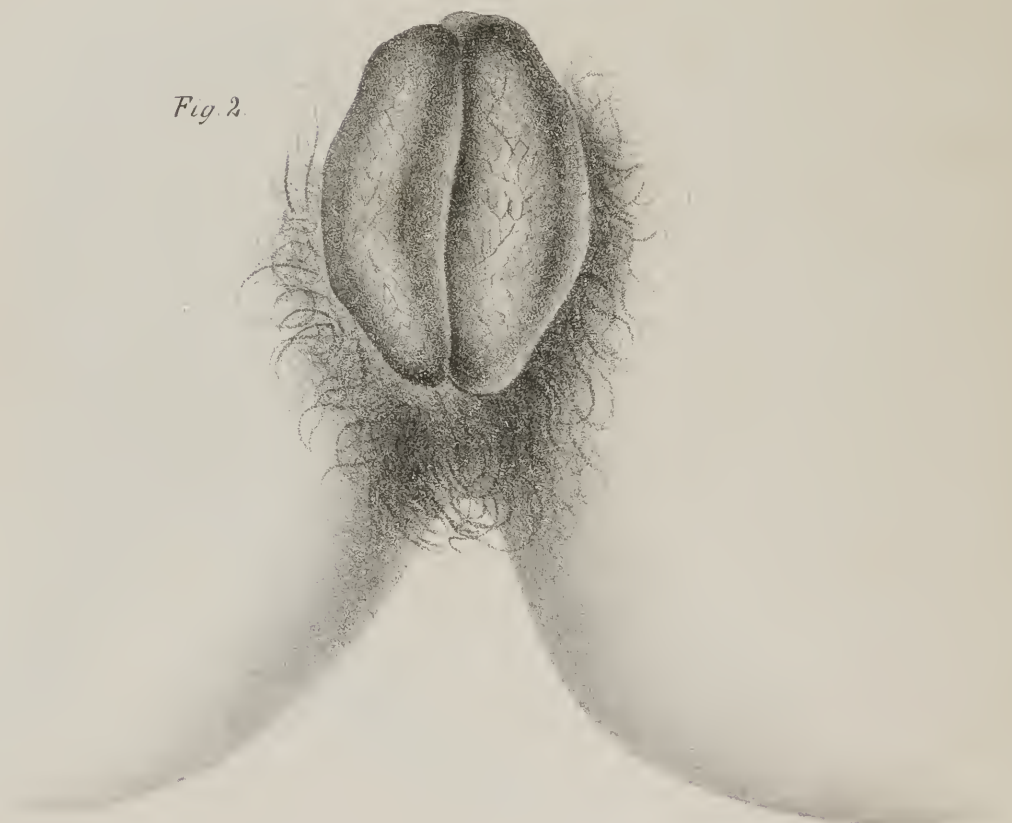


Fig. 1.



Fig. 2.



PLATE IV.

- FIG. I. A posterior view of complete prolapsus several inches of the rectum. (See pages 203, 204.) The case here depicted, was that of a youth who laboured under stone in the bladder. I performed the operation for lithotomy successfully, and the protrusion subsided.
- FIG. II. Chronic prolapsus of two lateral flaps of the mucous membrane. (See page 204.) The whitish protuberances surrounding the lateral flaps, are portions of hyperthrophied integument. (See explanation to fig. ii. plate ii.) This drawing was taken from Mr. M. I removed the flaps, and in a few days he returned to Albany quite well.

PLATE V.

- FIG. I. Prolapsus of a circular fold of the mucous membrane, which is hard and ulcerated in many points. (See page 212.)
- FIG. II. The skin about the anus thickened, indurated, and furrowed, from constant rubbing to relieve itching. A patch of eruption may be seen a short distance above and without the anus. (See page 220.)

Fig. 1.



Fig. 2.

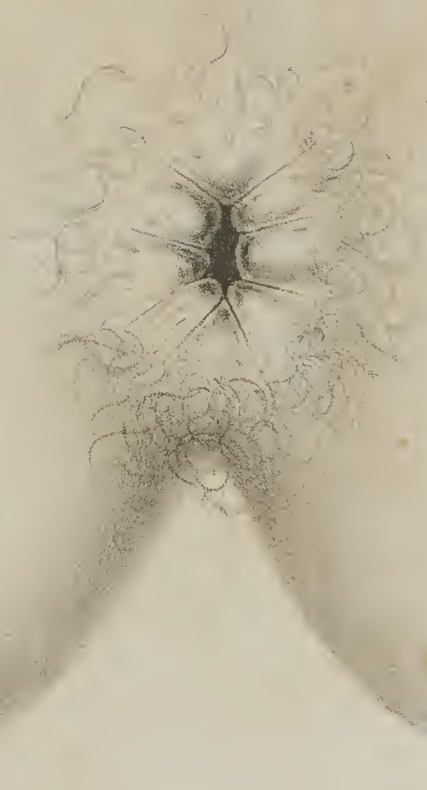


Fig 2.

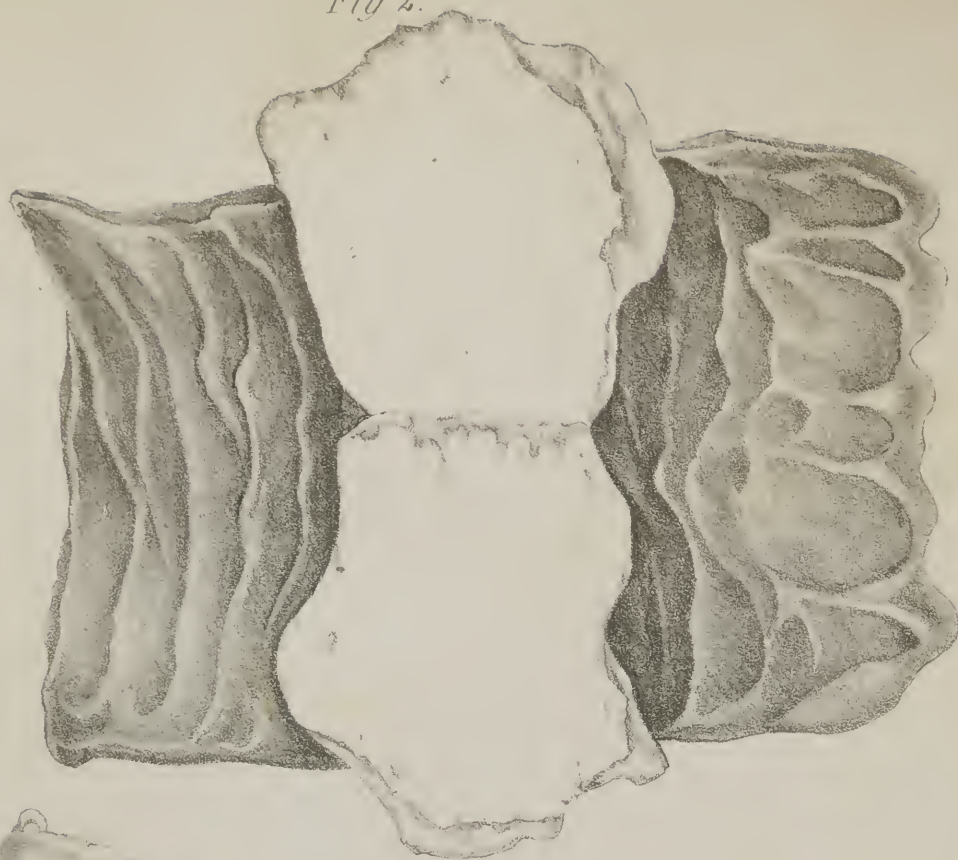


Fig. 1.

Fig. 3.



PLATE VI.

FIG. I. A bunch of mucous polypi, which I removed from the rectum of a West Indian gentleman.

FIG. II. Represents an ulcerated sarcomatous polypus of the rectum. It is of a fibro-lardaceous structure, pretty solid, of a yellowish white or dirty white colour, with some blood vessels running through it, and irregularly ulcerated on the surface. The subject of this disease was a gentleman, seventy-three years of age. For several years, he had laboured under angina pectoris, and for upwards of eighteen months he was led to suppose that he had, in addition to his old malady, a scirrhus-contracted state of the rectum. He died suddenly, during one of his attacks of angina, which depended upon organic lesion of the heart and aorta: thus, he was saved a few months suffering.

FIG. III. Excessive destruction of the skin and cellular tissue adjacent to the rectum, produced by gangrenous inflammation. A probe is passed beneath the strip of integument in front of the anus, to show the extensive devastation of the cellular membrane. The man whose case is here exhibited, was a waiter in one of the hotels. His constitution, which was never very good, was still farther impaired by late hours, eating unwholesome food in abundance, and drinking almost all liquors freely. (See page 234.)

PLATE V.

- FIG. I. Prolapsus of a circular fold of the mucous membrane, which is hard and ulcerated in many points. (See page 212.)
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Fig. 1.

Plate 1.



Fig 2.

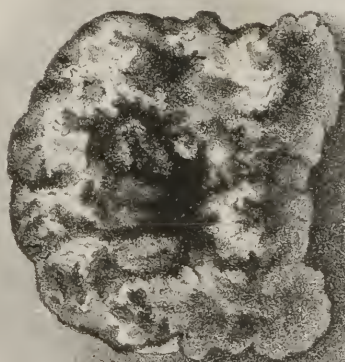


Fig. 1.

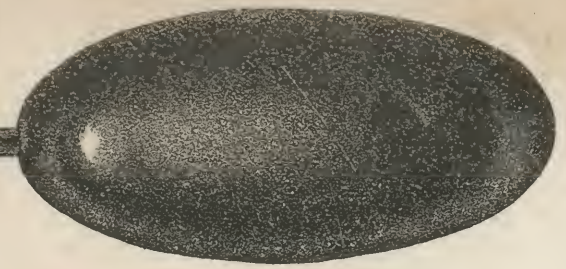


Fig. 2.

Fig. 3.



Fig. 8.

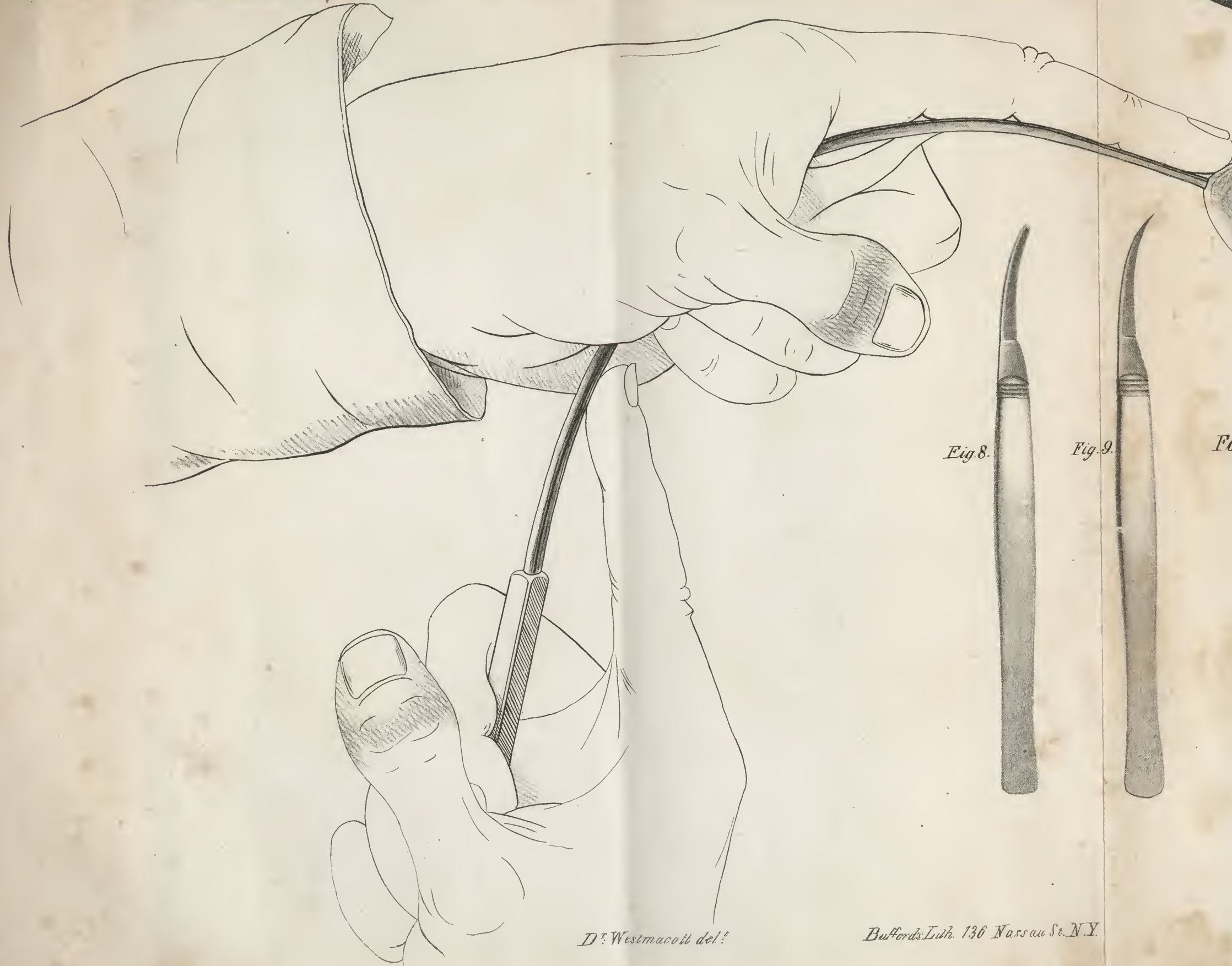
Fig. 9.

Fig. 4.

Fig. 6.

Fig. 5.

Fig. 7.



D^r. Westmacott del^t.

Bufford's Lith. 136 Nassau St. N.Y.

PLATE VIII.

- FIG. I. The ebony rectum bougie mounted on a stalk of whale-bone. (See page 284.)
- FIG. II. The method of introducing the bougie just described. (See page 284.)
- FIG. III. The fissure knife. (See page 105.)
- FIG. IV. The perineal pin. (See page 82.)
- FIG. V. The end to screw on when the needle is removed.
- FIG. VI. The needle.
- FIG. VII. The needle used in sewing the recto-vaginal partition. (See page 85.)
- FIG. VIII. The probe pointed bistoury recommended for small fistulæ in the substance of, or within, the sphincter ani. (See pages 254-5.)
- FIG. IX. The sharp pointed bistoury recommended for small incomplete internal fistulæ, situated in the substance of, or within, the sphincter ani. (See page 255.)

Fig. 1.

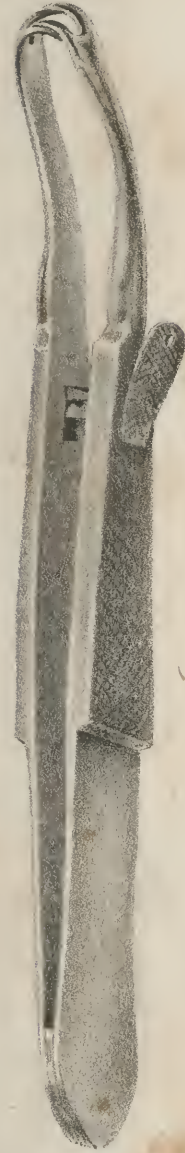


Fig. 4.



Fig. 2.



Fig. 3.



Fig. 5.

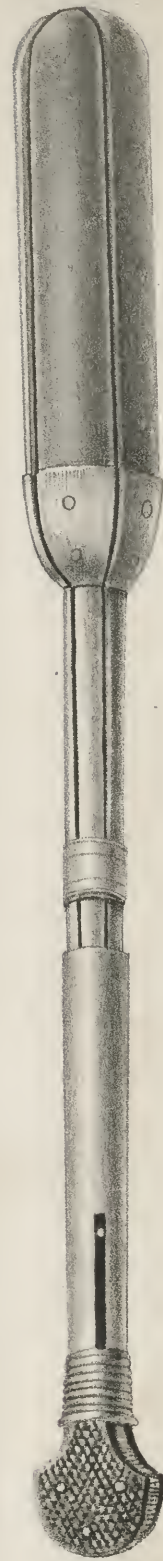


Fig. 6.

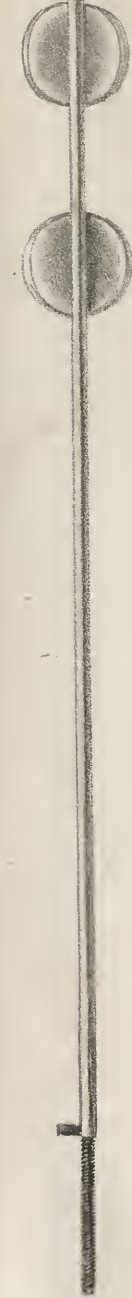


Fig. 7.



Fig. 8.



Fig. 9.



Fig. 10.



Fig. 11.

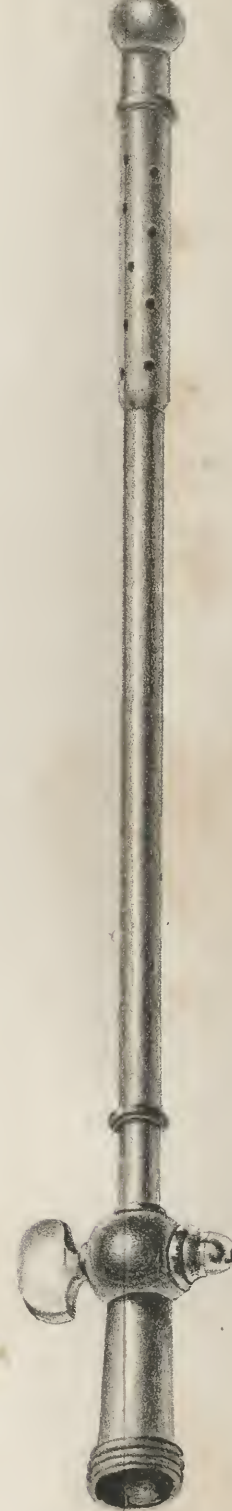


Fig. 12.

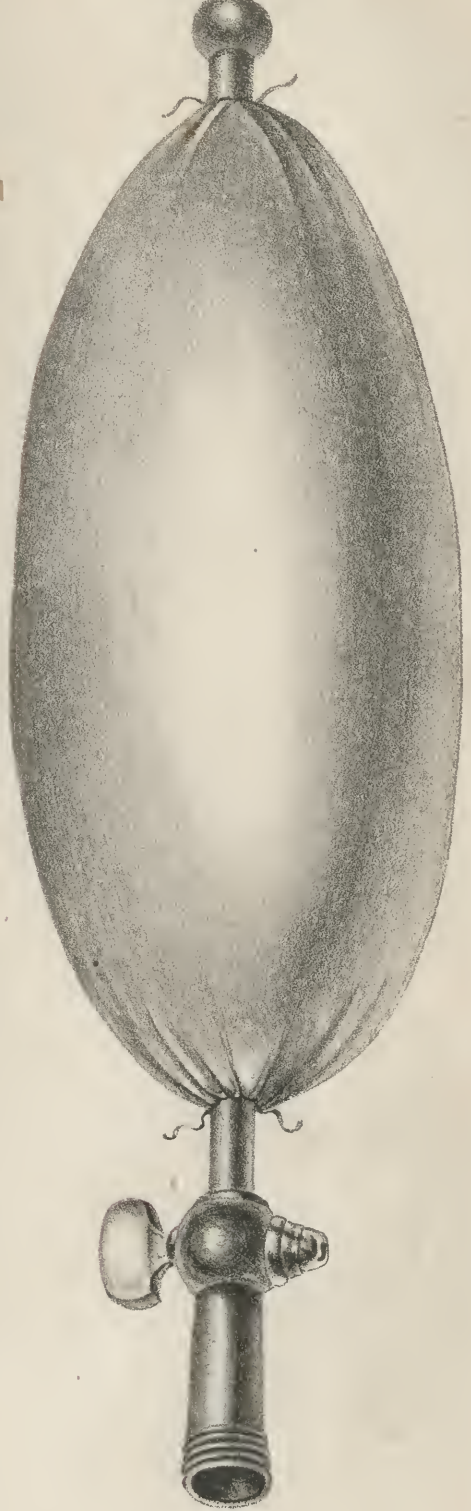
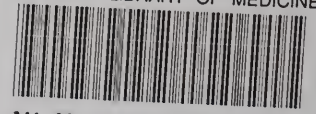


PLATE IX.

- FIG. I. Forceps for prolapsing internal hemorrhoidal tumours. (See page 188.)
- FIG. II. Forceps for withdrawing the needle. (See page 188-9.)
- FIG. III. Needle carrier armed with the needle. (See page 188.)
- FIG. IV. The needle. (See page 188.)
- FIG. V. The dilating rectum bougie. (See page 285.)
- FIG. VI. The wire which runs through it, with the plates attached.
- FIG. VII. The handle.
- FIG. VIII. The pin for securing the tube and handle together.
- FIG. IX. A view of the inside of one of the four ivory sections.
- FIG. X. A view of the plates looking from the distal extremity of the wire.
- FIG. XI. The tube of the instrument for stopping hemorrhage. (See page 185-6.)
- FIG. XII. The instrument for stopping hemorrhage with a portion of intestine tied over it—fit for use. (See page 185-6.)

THE END.

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